

IMAGES IN CARDIOLOGY.....

Ruptured thoracic aortic aneurysm resulting in cutaneous haematoma

An 81 year old woman presented with a three hour history of acute central chest pain radiating down her left arm. She had a history of mild chronic obstructive airways disease and hypertension but had been fit and well apart from slight dysphagia in the preceding week. Initial examination, chest x ray, ECGs, cardiac enzymes, and other routine blood tests were unremarkable. She was considered to have unstable angina and her initial treatment included aspirin 300 mg.

The following morning, the patient developed recurrent severe chest pain, now radiating through to her back. Examination revealed a large area of bruising extending from the submental region to mid-sternum (below left). She remained haemodynamically stable with symmetrical blood pressure and peripheral pulses. Haemoglobin, which was 13.4 g/dl on admission, had dropped to 10.4 g/dl.

Transthoracic computed tomography demonstrated an aneurysm of the descending thoracic aorta, distal to the origin of the left subclavian artery and measuring 6 cm in diameter. There was extensive subintimal haematoma extending into the mediastinum, with an associated haemothorax on the right (below right). The patient was transferred urgently to a specialist centre and the ruptured aneurysm was treated by endovascular stent placement. A thoracic aortic aneurysm should be considered in patients presenting with a history of dysphagia and chest pain. Cutaneous bruising is a rare but striking presentation of spontaneous rupture.

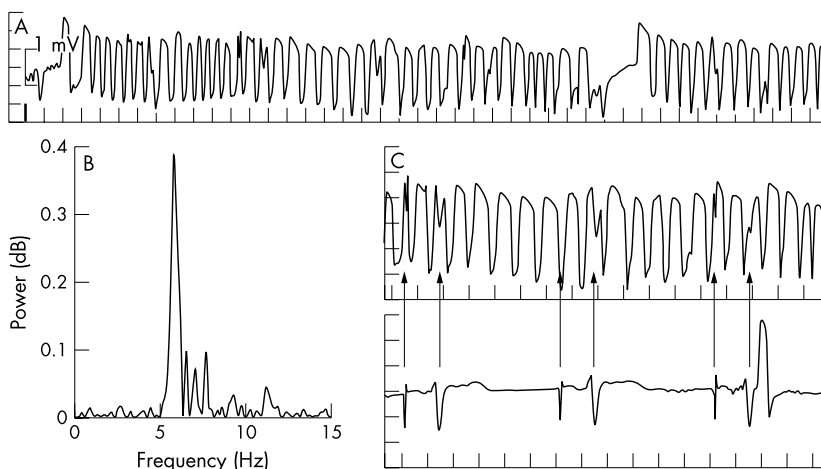
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Imitating ventricular tachycardia

We report on a 70 year old man with symptomatic atrioventricular node re-entry tachycardia and status post pacemaker implantation who underwent an electrophysiologic study for modulation of the slow pathway. The following night, the ICU monitoring alarm system indicated ventricular fibrillation (A). However, the patient was adequately responsive after waking, and showed no symptoms of dizziness. During the next hours, three similar episodes occurred. Spectral analysis of the signal showed a peak at 5.5 Hz (B). The patient was known to have Parkinson's disease for seven years. A resting tremor known to be in the range between 4 to 6 Hz is the most likely cause for these events. The muscular potentials are superposed on pacemaker signals and myocardial potentials, respectively (C).



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